SECTION IV

HCSNA ACTIVITIES AND RESPONSIBILITIES: MONITORING AND OVERSIGHT

Across the nation, there has been an intensified call to improve the assessment and reporting of quality and effectiveness of care provided through existing delivery systems. This trend has been heightened by growing indications that significant distinctions exist in the quality of care between various healthcare delivery systems. In many instances, the quality of care has been less than optimal. As with the implementation of any new healthcare system, the need to identify progress and validate the effectiveness of the Alliance program was identified as a critical factor from the very onset of the program. This section of the Annual Report describes the oversight and monitoring activities of HCSNA. The activities listed in this section form the foundation of the Health Care Safety Net Administration tasks. These activities are listed in more detail in the "HCSNA Monitoring and Evaluation Manual," which also provides details on the contract compliance terms and methods for the review process.

Organizational Structure

Operational Oversight Committee

HCSNA developed and implemented an Operational Oversight Committee and four subcommittees consistent with its strategic plan. The Committee and subcommittees consist of key individuals from DC Healthcare Alliance and the Department of Health. These committees serve as a vehicle for information dissemination and oversight of the Alliance contract. A brief update on the four subcommittees, their organization, and their activities follows.

Chair: Brenda L. Emanuel, HCSNA Deputy Director

Data and Reporting Oversight Subcommittee

The Data and Reporting Oversight Subcommittee was created as a result of the first "Data Summit." The Data Summit brought together providers and other subcontractors of the Alliance to discuss data collection, aggregation, standardization, and reporting issues. As a result of this first summit, it was clear that there was an ongoing need to meet to discuss data standardization and reporting issues.

Chair: Brenda L. Emanuel, HCSNA Deputy Director

Co-Chair: Joseph Tannenbaum, HCSNA Reporting Analyst

Public Information Oversight Committee

This committee provides oversight of the Alliance communications and public relations efforts. Its objective is to ensure that information for dissemination, whether oral, written, data, or for the media, is timely, accurate, and consistent with the goals and objectives of the DC Healthcare Alliance as established by the HCSNA. The first and foremost challenge was to establish a functional communications infrastructure that would streamline communications within the Alliance. The additional challenge was to keep all partners, providers, and stakeholders abreast of new developments.

Members of the subcommittee were composed of professional communications officers from the Department of Health and the Alliance. Collectively, this team will apply technology and creativity to ensure that critical Alliance-related information is efficiently and accurately disseminated to appropriate stakeholders.

The Annual Report is one of the tools that we will use to communicate with our stakeholders. Another tool will be the Quarterly HCSNA Report. This report will inform stakeholders on the progress that the Alliance has made in attaining its objectives.

There is a great need for communication between the approximately 30,000 enrolled members and the 800 or more healthcare professionals who provide medical care to the members. The challenge of harnessing and improving the flow of information between the Alliance's 28 community-based clinics and 7 hospitals is tremendous.

The HCSNA is working on developing a tool for capturing this vast information, deciphering it, and presenting it to stakeholders in a user-friendly format and a time-sensitive manner.

Chair: Greg Rhett, HCSNA Community Relations Specialist

Information Technology (IT) Oversight Subcommittee

The HCSNA IT Oversight Subcommittee held its first meeting in February 2002 to monitor the DC Health Care Alliance's IT components. Components include:

1. An information system that will support and facilitate the data management and warehousing needs of an integrated healthcare delivery system.
2. An IT system with the capabilities to provide the HCSNA with a timely, accurate, and sufficiently detailed data, statistical reports, and analyses regarding uninsured patients and the healthcare services they receive. This will include data regarding patient identities, demographic characteristics, place of residence, costs, utilization, and other information in computer-readable files.

Therefore, the IT Oversight Subcommittee has the responsibility for information technology and planning to ensure and support a patient-centered approach for care delivery within the Alliance. To date, the critical issues identified include: real-time electronic eligibility access; electronic data interchange for claims submission; centralized scheduling and coordination of care; electronic data flow for report development; outpatient pharmacy system development; and electronic patient records. These issues have been identified and an implementation workplan has been developed for each area. Problem solving and collaboration with the Clinical Quality Subcommittee, as well as grant funding and innovative information access models, are all scheduled for the upcoming months to further enable IT to continue to support the provision of care to the citizens of the District.

Chair: Cynthia Smith, Mercer Consulting
Co-Chair: Joseph Tannenbaum, HCSNA Reporting Analyst

Quality of Care Oversight Subcommittee

The HCSNA Quality of Care Subcommittee was instituted in August 2001 as a forum for collaboration between clinical staff across the various Alliance partners and the HCSNA to review quality and coordination of care issues and to identify and resolve issues impacting patient care. Since January 2002, this subcommittee has also served as the forum for HCSNA oversight and monitoring of Alliance clinical services. The focus of much of the efforts of this subcommittee is to build a patient-centered model for care delivery. This is a model where primary care is emphasized, and appropriate emergency and inpatient services are readily available when patients are faced with acute medical conditions. Since the formation of the subcommittee, various critical issues including prenatal care services,

community-based care management, inpatient care coordination, emergency room services, and clinical information tracking have been closely evaluated. Creative and sustainable opportunities for improvement have been identified and implemented. In the coming months, the subcommittee will continue to assess the clinical services provided by the Alliance and seek innovative ways to enhance care provision to uninsured residents of the District.

Chair: Paula Johnson, HCSNA Clinical Manager

Customer Service/Provider Satisfaction Oversight Subcommittee

The HCSNA Customer Service/Provider Satisfaction Subcommittee has met monthly since its creation in February 2002. Its key goals and objectives include:

- Provide oversight and monitoring of the Alliance on matters pertaining to customer service and provider satisfaction
- Ensure that there is a programwide customer and provider satisfaction system that elicits all complaints, issues, and praise
- Ensure that all issues are directed to the appropriate partner for a timely resolution.

The committee began its work by initially identifying and outlining the customer service infrastructure of each Alliance partner to understand existing processes. Next, the subcommittee identified potential customer service gaps. Finally, the subcommittee sought opportunities for addressing these gaps and increasing overall efficiency. Along with the task of understanding existing processes, the subcommittee also spent time developing standard definitions and drafting appropriate policies and procedures to ensure consistency in operations throughout the network.

In the first year, the subcommittee has successfully initiated program enhancements for a number of customer service areas (i.e., enhanced the specialty care referral process between the specialist and primary care providers; instituted a formulary exceptions process; drafted Alliance operational policies and procedures; and implemented an Alliance cultural compentency workplan). Also in year 1, the subcommittee has defined a clear process for reporting and tracking all complaints. Consistency in reporting complaints across all Alliance partners is a challenge that will continue for now and should be overcome in year 2.

In the next year, improving access to the pharmacy and reducing waiting periods for dental appointments and other related customer service issues will be of paramount importance.

This subcommittee is committed to making specific and systematic infrastructural improvements in the coming year. These improvements will be important tools as we move to enhance all services provided by Alliance partners and providers. Some of the key priorities issues for the coming year include:

- Improving reporting systems
- Ensuring efficient documentation of all complaints, issues, and recommendations
- Ensuring timely resolution of all complaints
- Enabling Alliance members to participate in monthly subcommittee meetings (to receive first-hand "consumer" suggestions and impressions of Alliance Services).

As this group continues its work, concerns and causal relationships to Alliance performance and patient and provider outcomes will be assessed and reported periodically.

The subcommittees of the Operational Oversight Committee have been successful in convening the multiple partners in the Alliance to accomplish the priorities as set forth by the HCSNA. A discussion of other oversight and monitoring activities of the HCSNA follows.

Early Monitoring System

The HCSNA reporting and monitoring efforts started with the development of an early monitoring system that used clinical utilization and operational information from existing data sources to monitor performance of the program. This information was tracked on a weekly, and often daily, basis to provide real time assessments of operational and clinical performance. Reports summarizing this information were presented to key stakeholders such as the Alliance Management, the Mayor's Office, and the Commission. In areas where information for monitoring was deemed critical, HCSNA worked collaboratively with the Alliance to implement data collecting and reporting initiatives. One such initiative was the Emergency Department monitoring effort that is described in greater detail in a later section of this report.

Focused Quality of Care Studies

In addition to the early monitoring reports, there was also a need to obtain targeted information on certain clinical issues of concern. This information was not available through the initial data systems and hence, required focused quality of care studies involving medical chart reviews. Some of the studies performed in the initial months of the program were focused on perinatal care services and on inpatient care management and discharge planning. Both these studies identified the need for a clearly defined process for care coordination both in the inpatient and the outpatient setting. The need for ensuring an information flow that supports the process for care coordination and transition to the primary care community-based setting was also identified.

Since the completion of these studies, the Alliance has taken steps to address gaps identified and to create a more streamlined system for care coordination. Aggressive measures were instituted to transfer patients requiring admission from the ER to hospital beds, as deemed clinically appropriate. Communication between Alliance partners was enhanced to facilitate comprehensive care delivery and appropriate placement in available care management programs. Specific tools have been designed and implemented to assist the discharge planning staff and to inform patients regarding follow-up appointments and other available care services. Through continued collaboration between the Alliance partners and the HCSNA, and a process of continuous quality improvement, we believe that the quality of care for the uninsured residents of the District of Columbia will continue to improve. Focused quality studies will continue to be an important part of this endeavor.

HCSNA Monitoring and Evaluation

As the Alliance program evolved, HCSNA identified the need for a long-term strategy for performance measurement where quality assurance and improvement are a priority and focused on specific core areas of the program. As part of its strategic planning process, HCSNA developed a monitoring and evaluation system that serves as a guide for its staff in performing oversight, monitoring, and evaluation responsibilities. HCSNA sought to create a system that ensures accountability among its healthcare delivery system providers. It did this through a process to measure contractor(s) performance and initiate and track needed corrective action to ensure quality of care, access to care, and financial viability.

Contractual Compliance Manual

Contractual Compliance is monitored through on-site and administrative reviews. The comprehensive Contract Compliance Manual

is intended to be a guide for HCSNA and its staff in performing their oversight and monitoring responsibilities. Some of the key sections in the manual include:

1. Monitoring activities and objectives
2. Schedule of reviews and reports
3. Contract Compliance Assessment Tool
4. Continuous improvement and corrective action process.

Based on a thorough assessment of the contract as well as the contractor's proposal, HCSNA staff identified specific contractual terms for which the Alliance is to be held accountable. Given the large number of requirements, HCSNA has prioritized the contract terms and is focusing on ensuring compliance in the most important areas. Work plans submitted by the Alliance were reviewed and significant strides were made towards achieving compliance in these areas of the program noted. Each of the following oversight and monitoring activities are conducted based on the terms and conditions in the Contract Compliance Assessment Tool. As specific subject matter reviews are conducted, the Contract Compliance Assessment Tool is reviewed to determine contract compliance. The first assessment described is Maintenance of Effort.

Maintenance of Effort

Under the guidelines of the program, HCSNA developed a mandate that requires District of Columbia hospitals and clinics to maintain historical levels of charity care. These baseline levels of care are established and/or defined by HCSNA. The legislative intent of setting a District-wide maintenance of effort baseline for all healthcare providers was twofold: (1) to ensure that the healthcare providers continued to meet their mandated charity care obligations as required under the State Health Care Planning and Development Agency (SHPDA) statutes; and (2) to ensure that the providers be fairly compensated for the healthcare services delivered to the District's eligible uninsured residents that are above their required charity care levels. The method was established and meetings have taken place to discuss the operationalizing of this program mandate.

Administrative Services Analysis

HCSNA developed and conducted the Alliance Administrative Services Analysis in the form of a desk audit and on-site assessment. This analysis is limited to the priority functions of eligibility, enrollment, and claims processing. The analysis evaluates the Alliance's compliance with administrative contractual terms. It also compares overall performance to the usual and customary administrative processes and best practices necessary for eligibility determination, member enrollment, and claims processing in an integrated, managed care setting. HCSNA is currently completing the Administrative Services Analysis. We made some preliminary findings and conducted an exit interview with Chartered Health Plan. HCSNA will be developing a report, which contains the findings of the Administrative Services Assessment.

The Administrative Service Analysis is conducted via a team approach using HCSNA staff with technical assistance and subject matter expertise from Mercer Government Human Services Consulting (Mercer). The timeline for completion should require 4-6 weeks and will be highly dependent on timely cooperation and assistance by the Alliance.

Financial Reconciliation Process

The HCSNA also requires a financial reconciliation to take place for the DC Healthcare Alliance contract. The task is to

review the compliance of the Greater Southeast Community Hospital Center (GSCHC) under the terms and conditions embodied in the agreement entered between the District and GSCHC. Gardiner, Kamya & Associates, P.C. (GKA) has been engaged by the District to complete the following tasks:

Task 1: Ascertain whether payments made were in accordance with the rates for healthcare services set forth in the Agreement.

Task 2: Compute budget reconciliation and other adjustments that are periodically required by the agreement, using reports prepared by GSCH and other available information.

Task 3: Identify any other needed information from the District or GSCH to:

(A) Ascertain whether payments were made in accordance with payment rates in the agreement

(B) Perform budget reconciliation.

The reconciliation will cover the following service areas:

1. Corrections services
2. School health
3. Healthcare and other miscellaneous services
4. Allowance for other hospital providers
5. Pharmacy services
6. Access maintenance costs
7. Administrative services
8. Accounting systems and procedures
9. Eligibility to participate in the program.

Alliance Data Warehouse Project

In Spring 2001, Mercer was contracted to assist the District of Columbia and the Department of Health in developing the Health Care Safety Net Administration following the closure of the DC General Hospital.

The primary goal was to create the infrastructure needed to effectively oversee and manage the implementation and ongoing operation of contractors responsible for service to the District's uninsured population. To accomplish the goals of this project, Mercer developed a data warehouse for the storage and reporting of Alliance member service utilization information from both claims and encounter data.

Mercer's objectives regarding management of the Alliance data were to:

1. Provide immediate information systems support to HCSNA
2. Develop the framework and data needed to monitor Alliance contract performance
3. Develop a comprehensive database and system oversight structure to support the ongoing needs of the HCSNA.

Mercer's approach for the design and operation of the data warehouse was to:

1. Map all existing data systems
2. Identify data elements needed to track contractual requirements:
   - Enrollment
   - Program access
   - Utilization
   - Clinical quality
   - Payment and claims management
3. Receive, validate, and analyze data submitted by the contractors
4. Map Alliance systems structure and data elements to reporting requirements and data warehouse structure
5. Build the data warehouse
6. Populate the data warehouse
   - Validate the data
   - Load historical data
   - Regular monthly updates to the database

7. Develop a set of management reports to be used by the HCSNA in the ongoing oversight and improvement of the system
8. Assist in the development and oversight of any needed corrective action plans.

At the present time, Mercer has established the process for accepting monthly claims and utilization data submissions from three prime Alliance contractors: Greater Southeast Community Hospital (GSE), Chartered Health Care (CHC), and the Unity Health Care (UHC) clinics. Utilization data submission processes from Children's National Medical Center (CNMC) and George Washington Hospital (GWH) are currently in development. The incoming data is edited and either loaded into the data warehouse or returned to the sender for correction of data errors. Population profiles, disease frequencies, service utilization, medical home analyses, and quality of care reports are currently under development.

By September 30, 2002, Mercer was scheduled to transition the data warehouse processing environment to HCSNA. All finalized production database structures, application programs and processes, and Alliance data will be transferred over to the DOH Information Technology division for ongoing maintenance and reporting.

Following the first year of data warehouse operations, the following sets of data are available for reporting and analysis:

1. DC General Baseline Data – Time period: 01/2000 – 07/2001
2. CHC Alliance Eligibility/Provider/Claims Data – Time period: 06/2001 – 07/2002
3. GSE Utilization Data (from HBOC) – Time period: 07/2001 – 12/2001
4. GSE Utilization Data (from Meditech) – Time period: 12/2001 – 07/2002

Note: In December 2001, GSE implemented a new hospital data information system. As such, the Alliance data received from GSE is divided into two sets, as listed above.

CHC is the claims administrator for the Alliance and thus, each Alliance organization submits claims data to CHC for payment. As a result, only the CHC claims data submissions contain a complete picture of all Alliance members receiving services from all participating Alliance contractors.

At this time, only GSE has submitted clinical utilization data. The Unity Clinics are still in the process of testing their Alliance data submission processes. Consequently, any utilization data reporting performed from the current data warehouse must be clearly documented, and it is understood that the outputs only apply to the Alliance population being served by GSE providers.

Mercer and DOH are in the process of transitioning the data warehouse from Mercer's operational control to DOH operational control. The two entities have agreed on a workplan and work schedule; established the needed test server environment at DOH; and prepared for the initial test system software and data installation.

In August 2002, Mercer and DOH staff completed the installation and testing of the Alliance data warehouse functionality in the DOH test environment. This included:

1. Oracle database management system software and SAS application software to be loaded on the test server
2. Current HCSNA data warehouse Oracle and SAS data structure, data, and application programs to be exported from the Mercer environment and installed in the DOH test environment

3. Full parallel testing of the DOH test environment against the Mercer production environment.

At this time, DOH is in the process of budgeting for the remaining components. The HCSNA has submitted purchase requisitions to obtain all required hardware and software to establish the production environment at DOH.

Performance Measurement System

HCSNA has identified the need for a long-term strategy for performance measurement based on the program mandates. Quality assurance and improvement have been identified as a priority that are focused on specific core areas of the program. Core performance indicators were identified from each of the following broad operational categories:

- Access to care
- Quality of care
- Utilization of services
- Financial performance
- Customer and provider satisfaction
- Management and administrative performance.

In each of these categories, core indicators were selected through an indepth review of reliable and valid data sources and the relevance of the indicator to the program and to the uninsured population in general. Wherever appropriate, nationally established measures as defined by organizations such as the National Center for Quality Assurance (NCQA) and Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) have been selected to ensure validity of the measures and that reasonable benchmark data is available to compare Alliance performance against national and regional best practices.

The focus of HCSNA's performance measurement efforts is to continue to foster a sense of collaboration across the various partners of the Alliance. In this regard, HCSNA recognizes the crucial role of community stakeholders and oversight bodies such as the Mayor's Reform Commission. Therefore, HCSNA has sought to obtain feedback from these stakeholders to ensure the selection of core indicators that best reflects the mandates and objectives of the Alliance program and are most relevant to the healthcare needs of the uninsured. The process used by HCSNA in finalizing its core performance indicator is summarized in the diagram that follows.

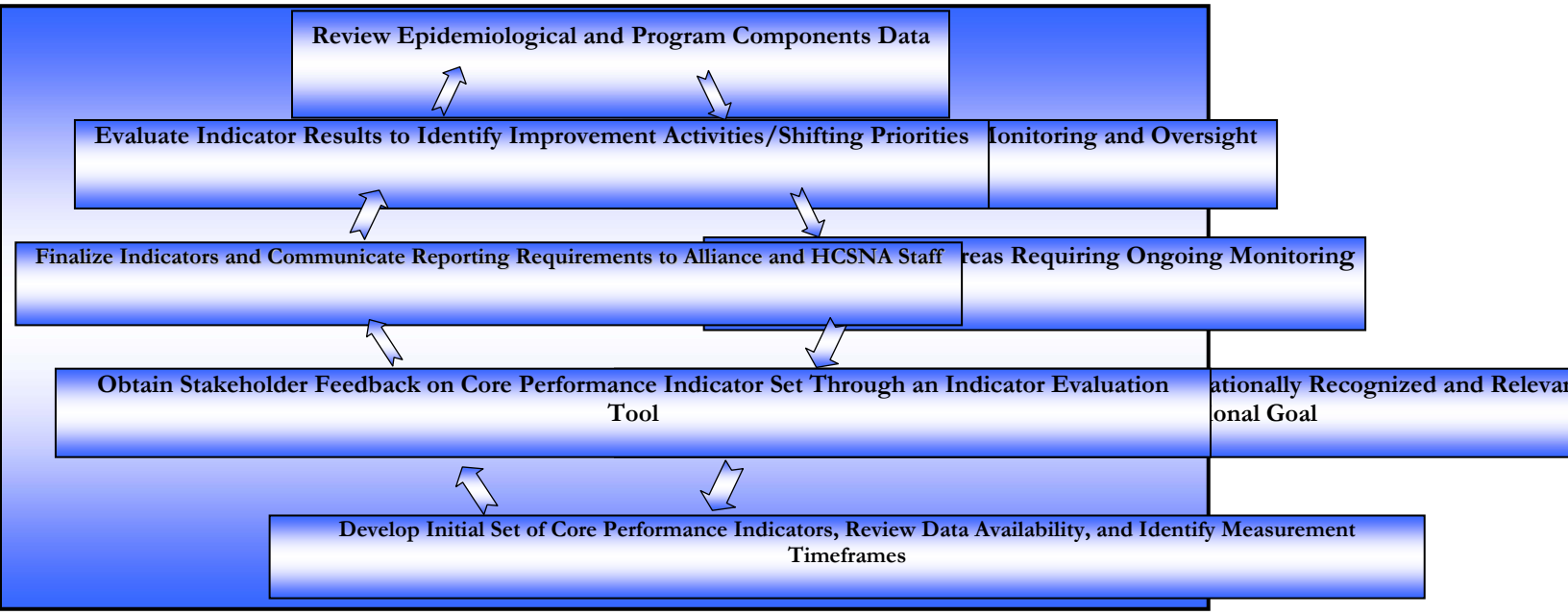
Performance Indicator

The process of developing performance indicators is graphically depicted on the following page. In selecting the appropriate indicators, it is recognized that some indicators are important from a day-to-day operational and process perspective and need to be evaluated on a more frequent basis. In the HCSNA performance measurement system, these indicators have been termed as "Short-term Indicators." A few examples of the 19 short-term indicators that have been selected are presented below.

1. Ratio of primary care providers (PCP) contracted with the network to the enrollees.
2. Rate of patients waiting greater than 6 hours in the emergency room from registration to disposition
3. Rate of primary care clinic visits occurring at the Alliance community clinics
4. Percentage of Alliance enrollees receiving care through the assigned medical home
5. Average length of stay for hospital inpatient admissions.

Results for many of the short-term indicators have been calculated from existing data sources such as the HCSNA data warehouse and through Alliance-generated reports and are discussed in detail later in this report.

Chart 4.1 Performance Indicator Development Process



There are other indicators that are important from a clinical and/or programmatic perspective but require onsite audits or review of a statistically appropriate number of medical records (clinical documentation). Because the measurement of these indicators is resource intensive, they are calculated less frequently and hence have been termed "Long-term Indicators." The HCSNA and the Alliance have developed a workplan for focused clinical record reviews and onsite audits to capture these long-term indicators of quality and performance. Of 15 core indicators identified in this group, a few examples are presented below:

- GeoAccess Reports documenting geographic distribution of physicians
- Percentage of patients with diabetes between 18 and 75 years of age that received appropriate diabetic screening tests such as Hb A1c and eye exams
- Percentage of patients aged 46-85 years with diagnosed hypertension that had their blood pressure controlled to 140/90
- Percentage of enrollees 35 years or older that were hospitalized for an acute myocardial infarction and were discharged with a prescription for a beta blocker
- Percentage of enrollees that are satisfied they receive care in a timely manner (through an annual satisfaction survey).

Some of the results for measures in this category are already available and are presented in Section 5 of this report. Others are in the process of being reviewed and results will be available through quarterly updates to be published by the HCSNA and through focused quality reports.